MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

00631 181
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Churchville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Dorothy W. Atkinson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 10 - 1936

8. AGE:

Years	Months	Days	If less than one day
9	4		hrs. min.

9. Birthplace: Churchville Harford Co. Md.
(Town, county, and state)
10. Usual occupation: Student
11. Industry or business

FATHER
12. Name: Allen J. Atkinson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna L. Sampson
15. Birthplace: Harford Co. Md

16. Informant: Mrs. Anna L. Atkinson
Address: Aberdeen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 29-1946 (month) (day) (year)
Cemetery or crematory: Smith Chapel
Location: Churchville Md

16. Funeral director: Henry Tipping & Sons
Address: Aberdeen Md

19. Jan. 28 1946 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26 1946, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Fracture of skull	
Due to:	
Due to:	
Other conditions: Fracture pelvis	—

(Include pregnancy within 3 months of death)

Major findings at operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 1/26/46
Where did injury occur? Aberdeen (City or town) Harford (County) Md. (State)
Injured at home, farm, industry, public place (where?) R.R. track
Means of injury: Hit by train Injured at work? no

23. SIGNATURE: Gerald C. Palmer M.D.
DEPUTY MEDICAL EXAMINER
HARFORD COUNTY
M. D. or other
Address: Bel Air, Md. Date signed: 1/27/46

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

00632

CERTIFICATE OF DEATH

Reg. Dist. No. 125

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 66 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 643 N. Stokes
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Caleb Adams

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Susan Adams (dec.)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 16 - 1876

8. AGE: Years	Months	Days	If less than one day
69	8	7	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Fisherman
11. Industry or business —

FATHER 12. Name	Unknown
FATHER 13. Birthplace	"
MOTHER 14. Maiden name	"
MOTHER 15. Birthplace	"

16. Informant Thomas W. Adams
Address 643 N. Stokes

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/28/46 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace
18. Funeral director Pennington & Son
Address Havre de Grace

19. 1-28 1946 A. L. Lewis M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1946 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 43 to Jan 25 1946
and that I last saw him alive on Jan 25, 46. 3 P.M.

Immediate cause of death	DURATION
Acute Pulmonary Edema	
Hypertension	
Due to Cerebral Hemorrhage	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles Foley M.D.
M. D. or other
Address Havre de Grace Date signed 1/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06633

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Rural — Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland — County: Harford
City or town: Rural — Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Shucks' Corner
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Reeves P. Andrews

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male M	White	Married

6.(b) Name of husband or wife: Minnie Andrews
6.(c) If alive, give age: alive years
7. Birth date of deceased (mo., day, yr.): June 18, 1886

8. AGE: Years 59 | Months 7 | Days 10 | If less than one day: hrs. min.

9. Birthplace: Alleghany Co., N.C.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Housewife
FATHER 12. Name: Martin Andrews
13. Birthplace: Alleghany Co., N.C.
MOTHER 14. Maiden name: Catharine Higgins
15. Birthplace: Alleghany Co. N.C.
16. Informant: Mrs. Reeves P. Andrews
Address: Bel-Air, Md. R.D.
17. Burial (Burial, cremation, or removal): Date thereof Jan 31 1946 (month) (day) (year)
Cemetery or crematory: Oak Grove Cem
Location: Darlington, Md.
16. Funeral director: H. B. Bailey
Address: Darlington, Md.
19. 1/30 1946 (Date rec'd by registrar) Priscilla Fouwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Janurary 28 1946 at 1:00 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 14 1945 to Jan. 28 1946
and that I last saw him alive on January 28 1946
Immediate cause of death: Pulmonary tuberculosis ? — DURATION: 2 years
and
Tuberculosis of the bone
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill, Md. Date signed: 1/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-A)

CERTIFICATE OF DEATH

00634

Reg. Diat. No. 185

1. PLACE OF DEATH:
County Harford
City or town Adams Grace (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Harford
City or town Bel Air (If outside city or town limits, write RURAL and give nearest town)
Street No. 18 W. Lemmon Avenue (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William L. Barker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife unknown 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 81 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name William L. Barker
13. Birthplace unknown

MOTHER 14. Maiden name unknown
15. Birthplace

19. Informant Carol Mc Lewis
Address Bel Air Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 26 1946 (month) (day) (year)
Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18. Funeral director W. S. Archer
Address Benson Md.

19. Jan. 24 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 19 46 at 11:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 46 to Jan 24 19 46 and that I last saw h. alive on Jan 20 19 46

Immediate cause of death	DURATION
Hemiplegia, left	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gerald C Palmer M.D.
M. D. or other
Address Bel Air, Md. Date signed 1/24/46

M

MARGIN RESERVED FOR BINDING

I

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 18 01635

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Rural Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Unknown County: Unknown

City or town: Unknown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: Unknown

3. (a) FULL NAME: Jonas Cann. Barnes

3. (b) Social Security Number: 214-26-6801

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Unknown

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: About 40 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Day Laborer

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Charles B. Olson 2nd

Address: Aberdeen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 26 1946 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: Near Aberdeen Md

18. Funeral director: Henry Taylor & Sons

Address: Aberdeen Md.

19. Jan. 26 1946 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 1946 at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Burned to death	
Due to: a burning building was involved — house burned down. C.O.D.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gerald C Palmer M.D. Deputy Medical Examiner Harford County M. D. or other

Address: Bel Air Md Date signed 1/22/46

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

00636

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occured: Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 32 Liberty St aberdeen
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Dr. Robert Bonner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Annie Gilleon
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): October 24, 1868

8. AGE: Years: 77 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Ontario Oxford Co., Canada (Town, county, and state)
10. Usual occupation: Professor
11. Industry or business

FATHER
12. Name: John Bonner
13. Birthplace: Canada

MOTHER
14. Maiden name: Nancy Trumbell
15. Birthplace: Canada

16. Informant: Mrs. Annie G. Bonner
Address: 32 Liberty St Aberdeen

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Jan. 24 1946 (month) (day) (year)
~~Cemetery or~~ crematory: Greenmount
Location: Baltimore, Md.

18. Funeral director: Henry Tarring & Sons.
Address: Aberdeen, Md.

19. Jan. 24 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 23 1946, at 11:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1943 to Jan 1946 and that I last saw him alive on Jan 23 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	abt.
Due to Arteriosclerotic Condition	6 yrs
Due to senile decline	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Ralph Hurley M.D.
Address: Churchville Md. Date signed: Jan 27 M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

00637

★ Reg. Dist. No. 18 5-

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, Institution, or street address where death occurred: 303 So. Washington St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 303 So. Washington St
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Phoebe Carty

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: John D. Carty
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Nov. 4, 1855

8. AGE:

Years	Months	Days	If less than one day
90	2	7	..... hrs. ..... min.

9. Birthplace: Harford Co. Md. (Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business:
FATHER — 12. Name: Garrett Ward
FATHER — 13. Birthplace: Md.
MOTHER — 14. Maiden name: Elizabeth Barnes
MOTHER — 15. Birthplace: Md.
16. Informant: Mrs Elizabeth L. Evans
Address: 303 So. Washington St. City.
17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) Jan. (day) 14 (year) 1946
Cemetery or crematory: Wesley and Chapel
Location: Harford Co. Md.
18. Funeral director: T. Madison Mitchell
Address: Havre de Grace Md.
19. Jan. 12 19 46 (Date rec'd by registrar) A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 11, 1946, at 11 15/4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 45, to Jan. 11 19 46
and that I last saw h[illegible] alive on Jan. 11, 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arterio Sclerosis	
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: A. L. Lewis M.D. M. D. or other
Address: Havre de Grace Md Date signed 1-12-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

00638

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Harford
City or town Edgewood (If outside city or town limits, write RURAL and give nearest town)
Street No. 15 Wilson St. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Vivian Daniel
3.(b) Social Security Number —

4. Sex Female
5. Color of race B.
6.(a) Single, married, widowed, or divorced Baby
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Jan. 11, 1946
8. AGE: Years · Months Days 6 If less than one day ... hrs. ... min.
9. Birthplace Havre de Grace, Harford, Maryland (Town, county, and state)
10. Usual occupation Infant
11. Industry or business
FATHER
12. Name Clarence Daniel
13. Birthplace Mississippi
MOTHER
14. Maiden name Margaret Brown
15. Birthplace Mississippi
16. Informant Margaret Daniel
Address Edgewood, Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof Jan. 20 46 (month) (day) (year)
Cemetery or crematory St James A.M.E.
Location Havre de Grace, Maryland
18. Funeral director Elmer E Bullock
Address 556 Lewis St. Havre de Grace, Md
19 Jan. 20 1946 (Date rec'd by registrar) W. L. Lawro M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1946, at 11:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-11- 1946, to 1-16 1946
and that I last saw her alive on 1-16 1946

Immediate cause of death Status lymphaticus — DURATION
Due to hyperplasia thymus gland
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results Enlarged thymus
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James G. Macaulay M.D. (M.D. or other)
Address 4 x Giles St. Havre de Grace Date signed 1-18-46

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (V-a)

00639

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County Harford

City or town Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Sta Hosp, Aberdeen Proving Ground, Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State New York County Delaware

City or town Jefferson
(If outside city or town limits, write RURAL and give nearest town)

Street No. RD #3
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME FLORENCE LIDIA DICKERSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Pvt. Louis C. Dickerson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 17, 1922

8. AGE:

Years	Months	Days	If less than one day
23	5	21	..... hrs. ..... min.

9. Birthplace Pleasant Brook, New York
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Forrest Hoffman

13. Birthplace Carylisle, New York

MOTHER 14. Maiden name Mildred Gillet

15. Birthplace Pirestown, New York

16. Informant Lewis C. Dickerson

Address Aberdeen Proving Ground

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Jan. 10 1946 (month) (day) (year)

Cemetery or crematory Leon Lappeus

Location Sharon Springs N.Y.

18. Funeral director Howard K. McComas & Son

Address Abingdon Md.

19. Jan. 10 1945 (Date rec'd by registrar) Marie M. Mouldale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 January 1946 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 January 1946 to 8 January 1946 and that I last saw her alive on 8 January 1946

Immediate cause of death	DURATION
Septicemia, source of infection unknown, cause unknown, acute, severe	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

endocarditis, recent rheumatic

Major findings of operations

Date of op.

Autopsy results Acute bacterial endocarditis; multiple emboli

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas S. Harvey M.D.
M. D. or other

Address Edgewood Arsenal Date signed Jan 9 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

06640

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Bykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Baby Boy Duncan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 16, 1946

8. AGE: Years | Months | Days | If less than one day: 12 hrs. min.

9. Birthplace Havre de Grace, Harford Co., Md.
(Town, county, and state)

10. Usual occupation Infant.

11. Industry or business

FATHER
12. Name Arnold Bush
13. Birthplace Maryland

MOTHER
14. Maiden name Mary Duncan
15. Birthplace Maryland

16. Informant Mary Duncan - Mother
Address Bykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/18/46 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace Md.

18. Funeral director Pennington & Son
Address Havre de Grace, Md.

19. Jan. 18 1946 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1946 at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1946 to Jan 17 1946 and that I last saw h[illegible] alive on Jan 17 1946

Immediate cause of death	DURATION
Cerebral and Pulmonary Congestion	
Due to Status Lymphaticus	
Due to Enormously enlarged Thymus	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Lewis M.D. M.D. or other
Address Havre de Grace, Md. Date signed 1-18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

06641

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jessie P. Gilbert

3.(b) Social Security Number: 218-05-0002

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Annie M Gilbert
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 11 - 1888

8. AGE: Years	Months	Days	If less than one day
57			..... hrs. ..... min.

9. Birthplace: Churchville, Md (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: George W Gilbert
13. Birthplace: Md

MOTHER
14. Maiden name: Martha M Gilbert
15. Birthplace: Md

16. Informant: Mrs Annie M Gilbert
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 2/46 (month) (day) (year)
Cemetery or crematory: Center Methodist
Location: Forest Hill, Md
18. Funeral director: Dean & Foster
Address: Bel Air, Md

19. 2/1 (Date rec'd by registrar) 1946 Priscilla Lowood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 1946, at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 - 1943, to Jan 31 1946 and that I last saw h.. alive on Jan 30 - 1946

Immediate cause of death	DURATION
Parkinsons Disease	10 yr
Due to: Chr Myocardial Disease	3 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md Date signed 1/31/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46) X

CERTIFICATE OF DEATH

Reg. Dist. No. 00642 78-

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Harford Memorial Hospital

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Stepney
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Eliza M. Gray

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: James K. Gray

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 19 - 1880

8. AGE: Years	Months	Days	If less than one day
65	7		...hrs. ...min.

9. Birthplace: Harford Co. Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: William T. Cullum
13. Birthplace: Harford Co Md

MOTHER
14. Maiden name: Martha J. Cullum
15. Birthplace: Harford Co Md

16. Informant: Mr. James K. Gray
Address: Aberdeen Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 16 1946 (month) (day) (year)

Cemetery or crematory: Bakers

Location: Aberdeen Md

18. Funeral director: Henry Tarring & Sons

Address: Aberdeen Md.

19. Jan. 15 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 1946 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 19 40 to Jan 13 19 46
and that I last saw h[illegible] alive on 1-13-46 19

Immediate cause of death	DURATION
Cardiac Decompensation	
Due to Carcinoma of Liver	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. Stear M.D. M. D. or other

Address: Aberdeen Md Date signed 1-13-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00643

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air Rural
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Chestnut Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sarah E Greenwalt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Thos. Greenwalt
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jany 30 - 1868

8. AGE:

Years	Months	Days	If less than one day
77			hrs. min.

9. Birthplace: Chestnut Hill, Md (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Noah Bull
13. Birthplace: Md
MOTHER 14. Maiden name: Ann Gratton
15. Birthplace: Md
16. Informant: Mrs Ella Streett
Address: Bel Air, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jany 11 / 46 (month) (day) (year)
Cemetery or crematory: Deer Creek
Location: Chestnut Hill
18. Funeral director: Dean & Foster
Address: Bel Air, Md
19. 1/10 19 46 Priscilla Forwood (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 9 19 46, at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 19 45 to Jany 9 19 46 and that I last saw h.. alive on Jan 4 19 46

Immediate cause of death	DURATION
Chr. Myocardial Disease	6 yrs.
Due to Coronary Thrombosis	30 Min
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W Sellard P. Hudson M. D. or other
Address: Forest Hill Md Date signed 1/10/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00644 / 181

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 5 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Franklin St

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Annie Elizabeth Hill

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband ~~or wife~~: Benjamin F. Hill

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 25 - 1870

8. AGE: Years	Months	Days	If less than one day
75	5		..... hrs. ..... min.

9. Birthplace: Aberdeen Md Harford Co.
(Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER
12. Name: William Henry Arnold
13. Birthplace: Aberdeen Harford Co. Md.

MOTHER
14. Maiden name: Laura Jane Cole
15. Birthplace: Aberdeen Harford Co. Md

16. Informant: Miss Edna M. Hill

Address: #15 Franklin St. Aberdeen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 7 - 46 (month) (day) (year)

Cemetery or crematory: Bakers

Location: Aberdeen Md

18. Funeral director: Henry Tanning Sons

Address: Aberdeen Md

19. Jan. 7 1946 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan - 5 - 1946 at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29 1945, to Jan 5 1946; and that I last saw h~~er~~ alive on Jan 4 1946

Immediate cause of death	DURATION
Lobar pneumonia	8 days
mitral insufficiency	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: T. P. Thompson M. D. or other

Address: Aberdeen Md Date signed: Jan. 7 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-0)

00645

CERTIFICATE OF DEATH

Reg. Diat. No. 182

1. PLACE OF DEATH:

County: Harford

City or town: Bel Air Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Bel Air Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: E. Broadway Apt
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Julia A. Holcomb

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Louis Holcomb

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 23 1860

8. AGE: Years: 86 | Months: 11 | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Meredith Lyons
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Dixie Tilley
15. Birthplace: North Carolina

16. Informant: Mrs. W. D. Simmons

Address: Bel Air Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 6 1946 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Near Bel Air Md

18. Funeral director: Henry Tarring Sons

Address: Aberdeen Md

19. 1/5 1946 Priscilla Forwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 3 1946 at 8:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1945 to Jan 1946

and that I last saw her alive on Jan 2 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	one hr.
Due to: Arteriosclerotic Hypertensive Disease	9 yrs
Due to: Arteriosclerotic C.V. Disease	9 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: J. Ralph Hartley M.D.
M. D. or other

Address: Churchville Md Date signed: Jan 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 120-a

CERTIFICATE OF DEATH

00646

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one hour
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? One hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perry Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1119 Fourth Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Barbara Ann Kimmey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 17, 1943

8. AGE:

Years	Months	Days	If less than one day
2	11	21	..... hrs. ..... min.

9. Birthplace: Havre de Grace, Harford, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Leonard A. Kimmey
13. Birthplace: Cambridge, Maryland

MOTHER
14. Maiden name: Beatrice Bell
15. Birthplace: Orange County, Virginia

16. Informant: Leonard A. Kimmey
Address: 1119 Fourth St., Perry Point, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 9, 1946 (month) (day) (year)
Cemetery or crematory: East New Market
Location: East New Market, Md.

18. Funeral director: Lee A. Satterwhite
Address: Perryville, Md.

19. Jan. 8 (Date rec'd by registrar) 19 46 L. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7 19 46, at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

	DURATION
Immediate cause of death: Gastro enteritis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harold C. Palmer Deputy Medical Examiner Harford County M. D. or other
Address: Bel Air, Md. Date signed: 1/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

00647

Reg. Diat. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alice Jane McCleary.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Chas C. McCleary.
6.(c) If alive, give age: 88 years

7. Birth date of deceased (mo., day, yr.): Apr 13 1867

8. AGE:

Years	Months	Days	If less than one day
78	9	2	hrs. min.

9. Birthplace: York Co Pa
(Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business
FATHER 12. Name: Jacob J. Flaherty.
13. Birthplace: York Co. Pa.
MOTHER 14. Maiden name: Mary R. Wright
15. Birthplace: York Co. Pa.
16. Informant: Charles C McCleary.
Address: Bel Air, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 18 1946 (month) (day) (year)
Cemetery or crematory: Slate Ridge Cem
Location: Delta, Pa
18. Funeral director: Hubert P. Hankins
Address: Delta Pa.
19. 1-15-1946 (Date rec'd by registrar) Priscilla Foxwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1946, at 4P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1 1940, to Jan 15 1946
and that I last saw h[illegible] alive on Jan 15 1946

Immediate cause of death	DURATION
Arteriosclerotic C V disease	5 yrs
Due to	
Due to	
Other conditions: Diabetes mellitus	—

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gerald C Palmer M.D.
M. D. or other
Address: Bel Air, Md Date signed 1/15/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

00648

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:
County Harford
City or town Norrisville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Norrisville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Columbus Payne McClung

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Nora McClung
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 23 1868

8. AGE: Years 77 | Months 6 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace Wakefield Co Md (Town, county, and state)

10. Usual occupation Retired Merchant

11. Industry or business General Store

FATHER 12. Name Robert Poynton McClung

FATHER 13. Birthplace Wakefield Co Md

MOTHER 14. Maiden name Hannah Catlett

MOTHER 15. Birthplace Harford Co Md

16. Informant Marvin R. McClung

Address Stewartstown Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 14 1946 (month) (day) (year)

Cemetery or crematory Centre

Location New Park Pa

18. Funeral director Howard Webb

Address Fawn Grove Pa

19. Jan. 14 1946 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1946 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4, 1946 to Jan. 11 1946 and that I last saw him alive on Jan. 10 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage.	
Hemiplegia.	
Due to Hypertension &	
Arteriosclerosis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Norman H. Stemmill M. D. on other

Address Stewartstown, Pa. Date signed 1/11/46.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06642

Reg. Dist. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No. Edmund & Eff.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Jessie B. Miller

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband ~~or wife~~: King S. Miller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 16. 1918

8. AGE: Years	Months	Days	If less than one day
30	4		hrs. ..... min.

9. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: None

FATHER
12. Name: Sue Prince
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Emma Dupree
15. Birthplace: South Carolina

16. Informant: Mrs. Edna Dennison

Address: 280 Oakridge Ave Summit N.J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 20-1946 (month) (day) (year)

Cemetery or crematory: Union M. E.

Location: Near Aberdeen Md

18. Funeral director: Henry Tarring Sons

Address: Aberdeen Md

19. Jan. 19 1946 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 17 1946 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-13 1946, to 1-17 1946

and that I last saw h[illegible] alive on 1-15 1946

Immediate cause of death	DURATION
Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Jane G. Macaulay M.D.
M. D. or other

Address: 914 Edwin Raynor Blvd Date signed 1-18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

01650

Reg. Dist. No. 185-

1. PLACE OF DEATH

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 717 Ontario

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Leo Michael Moore

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lena Lamm Moore

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 29. 1880

8. AGE: Years	Months	Days	If less than one day
66	6	9	..... hrs. ..... min.

9. Birthplace Principio Md.
(Town, county, and state)

10. Usual occupation Editor & Printer

11. Industry or business

FATHER — 12. Name Michael Moore

13. Birthplace Havre de Grace

MOTHER — 14. Maiden name Martha Kurtz

15. Birthplace Hagerstown Md.

16. Informant Mrs. Lena L. Moore (wife)

Address 717 Ontario St, Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/11/46 (month) (day) (year)

Cemetery or crematory Mt. Erin

Location Havre de Grace

18. Funeral director Pennington & Son

Address Havre de Grace

19. Jan. 10 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1946, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946, to June 8 1946 and that I last saw h.... alive on June 8 1946.

Immediate cause of death	DURATION
Cerebro Pulmonis Angina Pectoris	
Due to Coronary Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Charles J. Foley M.D. M. D. or other

Address Havre de Grace Date signed 1/10/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

00651

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel Air, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Maria Churchman Norris

3.(b) Social Security Number: C

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 27 - 1860

8. AGE: Years	Months	Days	If less than one day
85			..... hrs. ..... min.

9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual occupation: Retired - Nurse
11. Industry or business

FATHER
12. Name: John C Norris
13. Birthplace: Md

MOTHER
14. Maiden name: Mary J Crawford
15. Birthplace: Md

16. Informant: Miss Elizabeth Bradford
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: January 9 1946 (month) (day) (year)
Cemetery or crematory: St Mary's
Location: Emmorton, Md

18. Funeral director: Jesse A Foster
Address: Bel Air Md

19. 1-8 (Date rec'd by registrar) 19 46 Priscilla Fawvrd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7 19 46, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 1925, to Jan 1946
and that I last saw h... alive on Jan 6 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Bel Air Md Date signed 1/9/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-a

CERTIFICATE OF DEATH

06652

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15

1. PLACE OF DEATH:
County Harford
City or town Fountain Green
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 3 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. [illegible]
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME George Emory Pyle

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Elizabeth S. Pyle
6.(c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) March 24 1867

8. AGE: Years	Months	Days	If less than one day
78	9	23	hrs. min.

9. Birthplace Chestnut Hill Harford Co Md (Town, county, and state)
10. Usual occupation Assistant Mgr Metropolitan Insurance Co. Philadelphia
11. Industry or business Retired
FATHER 12. Name Wm Pyle
13. Birthplace Harford Co Md.
MOTHER 14. Maiden name Hester Lancaster
15. Birthplace Lancaster Co Pa
16. Informant Mrs Elizabeth S. Pyle
Address Jarrettsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 16 1946 (month) (day) (year)
Cemetery or crematory Loudon Park
Location Balto Md.
18. Funeral director Mather & Kurtz
Address Jarrettsville Md.
19. 1/16 1946 Priscilla Forwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1946, at 1:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 1946, to Jan 16 1946
and that I last saw him alive on Jan 15 1946

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	5 da
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other
Address Forest Hill Md. Date signed 1/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

Reg. Diat. No. 1183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Charles
City or town Stuart
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Charles
City or town Stuart P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William R Romsley

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Jessie V Romsley
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Dec 8, 1877

8. AGE: Years	Months	Days	If less than one day
68	1	4	hrs. min.

9. Birthplace Wheatley Co Md (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farming

FATHER
12. Name James Romsley
13. Birthplace Wheatley Co Md

MOTHER
14. Maiden name Mary E Stuart
15. Birthplace Wheatley Co Md

16. Informant Jessie V Romsley
Address Stuart Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 15 1946 (month) (day) (year)
Cemetery or crematory Vernon M. E.
Location White Hall Md
18. Funeral director W Howard Webb
Address Lane Grove

19. Jan. 15 1946 Thomas R. Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1946, at 11 A., M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 1946 to January 12 1946 and that I last saw h... alive on January 11 1946

Immediate cause of death	DURATION
Cardiac decline	
Due to Coronary	
Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Benjamin Bond M. D. or other
Address Cradiff Md Date signed 1-14-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

* THIN CORPORATE LIMITS O[F]

00654

Reg. Dist. No. 785

1. PLACE OF DEATH

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 565 N. Clair

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George Washington Richardson

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Negro

6.(a) Single, married, widowed, or divorced: Married

8.(b) Name of husband or wife: Hattie V. Richardson

8.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): April 5- 1865

8. AGE: Years: 80 | Months: 9 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Maryland (town, county and state)

10. Usual occupation: Retired Railroad Porter

11. Industry or business

FATHER 12. Name: Geo Washington Richardson

13. Birthplace: Maryland

MOTHER 14. Maiden name: Margaret Tower

15. Birthplace: Maryland

16. Informant: Hattie V. Richardson (Wife)

Address 565 N. Clair

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/24/46 (month) (day) (year)

Cemetery or crematory St. James A.M.E.

Location Havre de Grace

18. Funeral director: Pennington & Son

Address Havre de Grace Md.

19. 1-23 (Date rec'd by registrar) 19 46 A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 21 19 46 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 19 46, to Jan 21 19 46

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Occlusion	1-21-46
Due to	
Due to Arteriosclerosis	1944
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Carl L Cowen M. D. or other

Address Havre de Grace Date signed 1-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06655

Reg. Diat. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: North Carolina County: Ashe County
City or town: Grassy Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: matilda Sturgill Roupe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: Marshall C. Roupe
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 11 1860

8. AGE:

Years	Months	Days	If less than one day
85	3	7	hrs. min.

9. Birthplace: Alleghany Co N.C.
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business
FATHER 12. Name: James Sturgill
13. Birthplace: Alleghany Co N.C.
MOTHER 14. Maiden name: Sarah Emm Baldwin
15. Birthplace: N.C.
16. Informant: Ambrose F. Pugh
Address: Forest Hill Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 22-1946 (month) (day) (year)
Cemetery or crematory: New River
Location: Ash County N.C.
18. Funeral director: Martin Grunt
Address: Jamestown Md.
19. 1-18 1946 Priscilla Fawood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18 1946, at 5 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1946, to Jan 18 1946
and that I last saw h ed alive on Jan 18 1946
Immediate cause of death: Cerebral Hemorrhage
Due to: Advanced Age and
Grippe
Due to:
Other conditions: ✓

DURATION
24 hrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L P Snodgrass M. D. or other
Address: Darlington Md Date signed: 1/18/46

M

I MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

WITHIN CORPORATE LIMITS ?

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06656

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days.
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 13 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: White Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henry Charles Schilling **3.(b) Social Security Number:** none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of husband or wife: Charity Schilling
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1866

8. AGE: Years: 79 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Harford Co. Md.
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER
12. Name: Henry Schilling
13. Birthplace: "

MOTHER
14. Maiden name: Barnes
15. Birthplace: "

16. Informant: C. William Schilling
Address: White Hall, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 30-1946 (month) (day) (year)

Cemetery or crematory: Cyprus Chapel
Location: White Hall R.F.D.

19. Funeral director: Howard S. Mackelwee
Address: White Hall, Md.

19. Jan. 30 1946 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29 1946, at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17 1946, to Jan 29 1946, and that I last saw h[illegible] alive on Jan 29 1946.

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to: Hypertension	
Due to: Arterio sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. L. Lewis M.D. M. D. or other
Address: Havre de Grace, Md. Date signed: 1-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on FILM No. 100

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00657

Reg. Dist. No. 181

FEB 21 1946

1. PLACE OF DEATH:
County: Harford
City or town: Perryman
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Perryman
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: James Wesley Shinault

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Beatie Leonard
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Dec. 24 - 1887

8. AGE: Years	Months	Days	If less than one day
58 68		7	hrs. min.

9. Birthplace: Carroll Co. Va.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: Johnson Shinault
13. Birthplace: Carroll Co. Va.

MOTHER
14. Maiden name: Workman
15. Birthplace: Workman

16. Informant: Mrs. Beatie Shinault
Address: Perryman Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan. 3 1946 (month) (day) (year)
Cemetery or crematory: Spesutia
Location: Perryman Md.
18. Funeral director: Benny Tenney & Sons
Address: Aberdeen Md.

19. Jan. 3 1946 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1 1946, at 8.30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 26 1945, to Jan. 1 1946
and that I last saw him alive on January 1st 1946

Immediate cause of death	DURATION
Internal Hemorrhage	
Due to: Cancer of Stomach	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard D. Hellmuth M.D.
M. D. or other
Address: Perryman, Md. Date signed: Jan. 1. 46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(OVER)

(OVER)

Changed age of deceased to 58 yrs. on authorization of wife. Received no answer from the doctor. On April 6, 1946 received another authorization from the wife stating that the age of the deceased should be 68 yrs. and the birth date of the deceased should be December 24, 1877. See microfilm No. 101 - April 9, 1946.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

...THEIR CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore MHD

CERTIFICATE OF DEATH

00658

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford Mem. Hospital

City or town Havre de Grace Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Mem. Hospital

How long in hospital or institution? 36 hrs 25 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 456 Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Evelyn Hansell Short

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Ernest Short

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 3rd 1916

8. AGE:

Years	Months	Days	If less than one day
29	9	28	..... hrs. ..... min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Frank Hansell

13. Birthplace Virginia

MOTHER 14. Maiden name Virginia Alamode

15. Birthplace W. Virginia

16. Informant Ernest J. Short

Address 456 Green St. Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/4/46 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace Md.

18. Funeral director Pennington & Son

Address Havre de Grace Md.

19 Jan. 3 1946 A. L. Lewis M. D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1st 1946 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on Jan 1st 6:45 P.M. 1946

Immediate cause of death	DURATION
Intracerebral Hemorrhage	
Due to Hypertonic Nephritis	
Due to Acute Dilatation	
Other conditions Heart	
Cardiac Failure	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D. or other

Address Havre de Grace Md. Date Signed 1/4/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00659

Reg. Dist. No. 1825

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Harford
City or town Home de Grace - (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days - Thru - 45 mi
Hospital, institution, or street address where death occurred: Harford Memorial Hosp.
How long in hospital or institution? 6 days - 9 hrs - 45 min

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Harford
City or town Abingdon (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(d) If veteran, name war

3. (a) FULL NAME Susie Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	M.

6.(b) Name of husband or wife Charles Smith
6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) September 18, 1866

8. AGE: Years	Months	Days	If less than one day
79	3	14	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Joseph C. Howard
13. Birthplace Baltimore
MOTHER 14. Maiden name Mary E. Mullen
15. Birthplace Baltimore
16. Informant Mr. Chas. Smith - Husband
Address Abingdon, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan 5 1946 (month) (day) (year)
Cemetery or crematory Abingdon, Methodist Cemetery
Location Abingdon Maryland
18. Funeral director Howard K. McComas & Son
Address Abingdon Maryland
19. Jan 5 1946 (Date rec'd by registrar) Muriel M. Mondadale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1946, 6:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27 1945, to January 2 1946
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other conditions Cachexia	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Charles J. Foley Jr. M. D. or other
Address Abingdon Md. Date signed Jan 5 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

08660

Reg. Diat. No. 182

1. PLACE OF DEATH:
County HARFORD
City or town BEL AIR - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Kalmia Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Calvin Trusty

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

8.(b) Name of husband or wife Sarah Trusty 8.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75	6		hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace
MOTHER 14. Maiden name Unknown
15. Birthplace
16. Informant Sarah Trusty
Address Bel air Md R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 12-1946 (month) (day) (year)
Cemetery or crematory Clarks Chapel
Location
18. Funeral director Shaw & Foster
Address Bel Air - Md
19. 1/11 1946 Priscilla Forword (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1946 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6 1946, to Jan. 9 1946 and that I last saw him alive on Jan. 6 1946

	Interval between onset and death
Immediate cause of death Influenza - pneumonia	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. F. Van Fibbs M. D. or other
Address Bel Air, Md. Date signed Jan 10. 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

00661

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood Arsenal, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, Institution, or street address where death occurred:
Station Hospital, Edgewood Arsenal, Md.
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Minnesota County: —
City or town: North Field
(If outside city or town limits, write RURAL and give nearest town)
Street No.: —
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3. (a) FULL NAME: WALQUARTSEN, Ervin

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 17 January 1916

8. AGE: Years	Months	Days	If less than one day
29	11	15	...hrs. ...min.

9. Birthplace: Minneapolis, Minn. (Town, county, and state)
10. Usual occupation: U.S. Army
11. Industry or business: "

FATHER
12. Name: Marin Walquartsen
13. Birthplace: Hayfield, Minn.

MOTHER
14. Maiden name: Inger K. Walquartsen
15. Birthplace: Norway

16. Informant: U.S. Army records
Address: —

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Jan. 2, 1946 (month) (day) (year)
Cemetery or crematory: Anderson N. Veaux Funeral Chapel
Location: North Field Minn.
18. Funeral director: Howard K. McCormack
Address: Abingdon Maryland
19. Jan 2 1946 (Date rec'd by registrar) Marie M. Mondale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 January 1946, at 11.10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 December 1945, to 1 January 1946
and that I last saw him alive on 1 January 1946

Immediate cause of death	DURATION
Suicide by hanging by neck, intentionally self-inflicted	— —
Due to: — —	
Due to: — —	
Other conditions: Sprain, sacroiliac, chronic	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: Fractured hyoid bone, pulmonary emphysema
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 1 Jan 46
Where did injury occur? Station Hospital, (City or town) Edgewood Arsenal, (County) Md. (State)
Injured at home, farm, industry, public place (where?): Army hospital
Means of injury: Hanging, self-inflicted Injured at work? no

23. SIGNATURE: Lawrence H. Owsley, Capt M.C.
LAWRENCE H. OWSLEY, Capt M.C. M. D. or other
Address: Station Hospital, Edgewood Arsenal, Md. Date signed: Jan 2 46

00662

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
110 Weber St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 110 Weber St
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME Dorothea Maye West

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wm. M. West
6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): Apr. 3, 1914

8. AGE: Years	Months	Days	If less than one day
31	9	5	hrs. min.

9. Birthplace: Mass. (Town, county, and state)
10. Usual occupation: House Duties
11. Industry or business

FATHER
12. Name: (unk.) Thomas
13. Birthplace: unk.

MOTHER
14. Maiden name: Katherine Gottholm (unk.)
15. Birthplace: Ireland

16. Informant: Mr. William M. West
Address: 110 Weber St. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 4 1946 (month) (day) (year)
Cemetery or crematory: Rock Run
Location: Harford Co.
18. Funeral director: F. Madison Mitchell
Address: Havre de Grace, Md.

19. Jan. 2 1946 (Date rec'd by registrar) A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 1 1946 at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to Jan. 1 1946 and that I last saw h[illegible] alive on Jan. 1 1946

Immediate cause of death	DURATION
Pulmonary Edema	1 day
Due to: Carcinoma in Lungs	4 yrs.
Due to: Tuberculosis (Pulmonary)	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Havre de Grace Date signed: 1/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

00663

Reg. Diat. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, Institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Md. County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 319 Freedom Alley

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Faye M. Whittington

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 8, 1942

8. AGE:

Years	Months	Days	If less than one day
3	1	19	..... hrs. ..... min.

9. Birthplace: Mc Daniel, Md.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace

MOTHER

14. Maiden name: Ruth J. Whittington

15. Birthplace: Va

16. Informant: Mrs. Ruth J. Stansbury

Address: 319 Freedom Alley City.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 30 1946 (month) (day) (year)

Cemetery or crematory: John Wesley Ch. Yard.

Location: Talbot Co. Md.

18. Funeral director: R. Madison Mitchell

Address: Havre de Grace, Md.

19. Jan. 29 19 46 (Date rec'd by registrar) G. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27 19 46 at 6 25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 26 19 46 to Jan 27 19 46

and that I last saw her alive on Jan. 27 19 46

Immediate cause of death	Pneumonia, Colon	DURATION
Due to		
Due to		
Other conditions	Burn of Abdomen	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James G. Macauley M.D. M. D. or other

Address: 319 Ed. Havre de Grace Date signed 1-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 106a

CERTIFICATE OF DEATH

00664

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos
Hospital, institution, or street address where death occurred: Edmond St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Rocks
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Arthur E. Wilson

3.(b) Social Security Number: 215-05-0810

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Mayfield Bellebeau
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 14, 1894

8. AGE:

Years	Months	Days	If less than one day
51	8		hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Thomas E. Wilson
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Sarah Jones
15. Birthplace: Pennsylvania

16. Informant: William J. Wilson
Address: Rocks, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 25 1946 (month) (day) (year)
Cemetery or crematory: Lawn Grove
Location: Getzville, Pa.
18. Funeral director: Henry Jarrings & Sons
Address: Aberdeen, Md.

19. Jan. 25 1946 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 21 19 46, at 9:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-10-46 19 46, to 1-21 19 46 and that I last saw him alive on 1-18- 19 46

Immediate cause of death	DURATION
Due to: Bronchitis & Asthma	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jane E. Macauley, M.D.
M. D. or other
Address: 614 Erie St Havre de Grace Date signed: 1-23-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170c)

CERTIFICATE OF DEATH

00665

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hosp.
How long in hospital or institution? abt 1 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Penna County Schuylkill
City or town Shenandoah (If outside city or town limits, write RURAL and give nearest town)
Street No. 202 So. Ferguson St. (If rural, give LOCATION)
2.(a) If veteran, name war No II

3.(a) FULL NAME ~~Alexander~~ Andrew Yanalavage
3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Divorced
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Feb 14-1905

8. AGE: Years	Months	Days	If less than one day
40	11	8	... hrs. ... min.

9. Birthplace Shenandoah, Penna. (Town, county, and state)
10. Usual occupation Labor
11. Industry or business Canning Industry
FATHER 12. Name Michael Yanalavage
13. Birthplace Poland Europe
MOTHER 14. Maiden name Anna Szukiec
15. Birthplace Poland Europe
16. Informant Mrs Anna Yanalavage
Address 202 S. Ferguson St Shenandoah Pa
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 26-1946 (month) (day) (year)
Cemetery or crematory St Stanislaus
Location Shenandoah Penna.
18. Funeral director Leonard J. Went
Address 601 W. Mahanoy Ave Mahanoy City Pa.
Mahanoy City
19. 1-23 1946 W. A. Lewis M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1946, at 7P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Fracture cervical vertebra	-
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 1/21/46
Where did injury occur? Aberdeen (City or town) Harford (County) Md (State)
Injured at home, farm, industry, public place (where?) U.S. Route 40
Means of injury Hit by truck Injured at work? no

23. SIGNATURE Gerhard C Palmer M.D. Deputy Medical Examiner Harford County M. D. or other
Address Bel Air, Md Date signed 1/22/46

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
VS A15